

# Your Benefit Summary

## Personal Option Plan



Copay	What You Pay	Calendar Year Out-of-Pocket Maximum	Calendar Year Deductible
\$15	20% coinsurance (after deductible)	\$6,350 per person \$12,700 per family (2 or more)	\$2,000 per person \$4,000 per family (2 or more)

### Important information about your plan

This summary provides only highlights of your benefits. To view your plan details, register and log in at [www.myProvidence.com](http://www.myProvidence.com).

- Your deductible is included in the out-of-pocket maximum amount listed above.
- Some services and penalties do not apply to out-of-pocket maximums.
- Prior authorization is required for some services.
- This plan only provides benefits for medically necessary services when provided by in-network physicians or providers.
- View a list of Providence Signature network providers and pharmacies at [www.ProvidenceHealthPlan.com/providerdirectory](http://www.ProvidenceHealthPlan.com/providerdirectory).
- Limitations and exclusions apply to your benefits. See your Member Handbook for details.

Personal Option Plan Benefit Highlights	After you pay your calendar year deductible, then you pay the following for covered services
✓ No deductible needs to be met prior to receiving this service	Copay or Coinsurance (from in-network providers only)
<b>On-Demand Provider Visits</b>	
<ul style="list-style-type: none"> <li>• Virtual visits to a Primary Care Provider by phone &amp; video (ExpressCare Virtual) or by Web-direct Visits</li> <li>• Providence ExpressCare Retail Health Clinic</li> <li>• Virtual visits to a Specialist by phone &amp; video</li> </ul>	Covered in full ✓ Covered in full ✓ \$10 / visit ✓
<b>Preventive Care</b>	
<ul style="list-style-type: none"> <li>• Periodic health exams and well-baby care</li> <li>• Routine immunizations; shots</li> <li>• Colonoscopy (age 50 +)</li> <li>• Gynecological exams (calendar year) and Pap tests</li> <li>• Mammograms</li> <li>• Tobacco cessation, counseling/classes and deterrent medications</li> </ul>	Covered in full ✓ Covered in full ✓ Covered in full ✓ Covered in full ✓ Covered in full ✓ Covered in full ✓
<b>Physician / Provider Services</b>	
<ul style="list-style-type: none"> <li>• Office visits to Primary Care Provider</li> <li>• Office visits to Alternative Care Provider (Chiropractic manipulation &amp; acupuncture services are covered only if a separate benefit has been purchased by your employer. Consult your member materials for these benefits.)</li> <li>• Office visits to Specialists/Other Providers</li> <li>• Allergy shots and serums</li> <li>• Infusions and injectable medications</li> <li>• Surgery; anesthesia in an office or facility</li> <li>• Inpatient hospital visits</li> </ul>	\$15 / visit ✓ \$15 / visit ✓ \$25 / visit ✓ 20% 20% 20% 20%
<b>Diagnostic Services</b>	
<ul style="list-style-type: none"> <li>• X-ray and lab services</li> <li>• High-tech imaging services (such as PET, CT or MRI)</li> <li>• Sleep studies</li> </ul>	20% ✓ 20% ✓ 20% ✓
<b>Emergency and Urgent Services</b>	
<ul style="list-style-type: none"> <li>• Emergency services (For emergency medical conditions only. If admitted to hospital, copayment is not applied; all services subject to inpatient benefits.)</li> <li>• Urgent care services (for non-life threatening illness/minor injury)</li> <li>• Emergency medical transportation (air and/or ground) (Emergency medical transportation is covered under your in-network benefit, regardless of whether or not the provider is an in-network provider)</li> </ul>	\$250 ✓ \$25 / visit ✓ 20%

Personal Option Plan Benefit Highlights (continued)	Copay or Coinsurance
<b>Hospital Services</b> <ul style="list-style-type: none"> <li>● Inpatient/Observation care</li> <li>● Rehabilitative care (Limited to 30 days per calendar year. Limits do not apply to Mental Health Services.)</li> <li>● Habilitative care (Limited to 30 days per calendar year. Limits do not apply to Mental Health Services.)</li> <li>● Skilled nursing facility (Limited to 60 days per calendar year)</li> <li>● Temporomandibular joint (TMJ) services (Inpatient and/or outpatient services combined limit of \$1,000 per calendar year/\$5,000 per lifetime)</li> </ul>	20% 20% 20% 20% 50%
<b>Outpatient Services</b> <ul style="list-style-type: none"> <li>● Outpatient surgery, infusion, dialysis, chemotherapy, radiation therapy (Prior authorization required for outpatient hospital-based infusions)</li> <li>● Colonoscopy (non-preventive)</li> <li>● Temporomandibular joint (TMJ) service (Inpatient and/or outpatient services combined limit of \$1,000 per calendar year/\$5,000 per lifetime)</li> <li>● Outpatient rehabilitative physical therapy (Limited to 30 visits combined with OT and ST per calendar year. Limits do not apply to Mental Health Services.)</li> <li>● Outpatient rehabilitative occupational and speech therapy (Limited to 30 visits combined with PT per calendar year. Limits do not apply to Mental Health Services.)</li> <li>● Outpatient habilitative services: physical, occupational or speech therapy (Limited to 30 visits per calendar year. Limits do not apply to Mental Health Services.)</li> </ul>	20% 20% 50% 20% ✓ 20% 20%
<b>Maternity Services</b> <ul style="list-style-type: none"> <li>● Prenatal office visits</li> <li>● Delivery and postnatal services</li> <li>● Inpatient hospital/facility services</li> <li>● Routine newborn nursery care</li> </ul>	Covered in full ✓ \$150 / delivery ✓ 20% 20% ✓
<b>Medical Equipment, Supplies and Devices</b> <ul style="list-style-type: none"> <li>● Medical equipment, appliances and supplies</li> <li>● Diabetes supplies (such as lancets, test strips and needles)</li> <li>● Prosthetic and orthotic devices (removable custom shoe orthotics are limited to \$200 per calendar year, deductible waived)</li> </ul>	20% 20% ✓ 20%
<b>Mental Health / Chemical Dependency</b> (All services, except outpatient provider office visits, must be prior authorized. For information, please call 800-711-4577.) <ul style="list-style-type: none"> <li>● Inpatient and residential services</li> <li>● Day treatment, intensive outpatient and partial hospitalization services</li> <li>● Applied behavior analysis</li> <li>● Outpatient provider office visits</li> </ul>	20% 20% 20% \$15 / visit ✓
<b>Home Health and Hospice</b> <ul style="list-style-type: none"> <li>● Home health care</li> <li>● Hospice care</li> </ul>	20% Covered in full ✓

## Your guide to the words or phrases used to explain your benefits

### **Coinsurance**

The percentage of the cost that you may need to pay for a covered service.

### **Copay**

The fixed dollar amount you pay to a health care provider for a covered service at the time care is provided.

### **Deductible**

The dollar amount that an individual or family pays for covered services before your plan pays any benefits within a calendar year. The following expenses do not apply to an individual or family deductible:

- Services not covered by your plan.
- Fees that exceed usual, customary and reasonable (UCR) charges as established by your plan.
- Penalties incurred if you do not follow your plan's prior authorization requirements.
- Copays and coinsurance for services that do not apply to the deductible.

### **Formulary**

A formulary is a list of FDA-approved prescription drugs developed by physicians and pharmacists, designed to offer drug treatment choices for covered medical conditions. The Providence Health Plan formulary includes both brand-name and generic medications.

### **In-Network**

Refers to services received from an extensive network of highly qualified physicians, health care providers and facilities contracted by Providence Health Plan for your specific plan. Generally, your out-of-pocket costs will be less when you receive covered services from in-network providers.

### **Limitations and Exclusions**

All covered services are subject to the limitations and exclusions specified for your plan. Refer to your member handbook or contract for a complete list.

### **Out-of-Pocket Maximum**

The limit on the dollar amount you will have to spend for specified covered health services in a calendar year. Some services and expenses do not apply to the out-of-pocket maximum. See your Member Handbook for details.

### **Primary Care Provider**

A qualified physician or practitioner that can provide most of your care and, when necessary, will coordinate care with other providers in a convenient and cost-effective manner.

### **Prior authorization**

Some services must be pre-approved, your in-network provider will request prior authorization for these services.

### **Usual, Customary & Reasonable (UCR)**

Describes your plan's allowed charges for services that you receive from an out-of-network provider. When the cost of out-of-network services exceeds UCR amounts, you are responsible for paying the provider any difference. These amounts do not apply to your out-of-pocket maximums.

### **Retail Health Clinic**

A walk-in health clinic, other than an office, urgent care facility, pharmacy or independent clinic that is located within a retail operation. A Retail Health Clinic provides same-day visits for basic illness and injuries or preventive services.

### **Virtual visit**

Visit with a Network Provider using secure internet technology such as Providence Express Care phone and video visits or Web-direct Visits.

### **Web-direct Visit**

A consultation with Network Provider using an online questionnaire to collect information to diagnose and treat common conditions such as cold, flu, sore throat, allergies, earaches, sinus pain or UTI.

### **Contact us**

Headquartered in Portland, our customer service professionals have been proudly serving our members since 1986.



Portland Metro Area: **503-574-7500**  
All other areas: **800-878-4445**  
TTY: **711**



Have questions about your benefits and want to contact us via email? Go to our website at:  
[www.ProvidenceHealthPlan.com/contactus](http://www.ProvidenceHealthPlan.com/contactus)

## Non-discrimination Statement

Providence Health Plan and Providence Health Assurance comply with applicable Federal civil rights laws and do not discriminate on the basis of race, color, national origin, age, disability, or sex. Providence Health Plan and Providence Health Assurance do not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Providence Health Plan and Providence Health Assurance:

- Provide free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provide free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you are a Medicare member who needs these services, call 503-574-8000 or 1-800-603-2340. All other members can call 503-574-7500 or 1-800-878-4445. Hearing impaired members may call our TTY line at 711.

If you believe that Providence Health Plan or Providence Health Assurance has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with our Non-discrimination Coordinator by mail:

Providence Health Plan and Providence Health Assurance  
Attn: Non-discrimination Coordinator  
PO Box 4158  
Portland, OR 97208-4158

If you need help filing a grievance, and you are a Medicare member call 503-574-8000 or 1-800-603-2340. All other members can call 503-574-7500 or 1-800-878-4445. (TTY line at 711) for assistance. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail or phone at:

U.S. Department of Health and Human Services  
200 Independence Avenue SW - Room 509F HHH Building  
Washington, DC 20201  
1-800-368-1019, 1-800-537-7697 (TTY)

Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.

## Language Access Information

ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call 1-800-878-4445 (TTY: 711).

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-878-4445 (TTY: 711).

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-800-878-4445 (TTY: 711).

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-800-878-4445 (TTY: 711)。

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-800-878-4445 (телетайп: 711).

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-878-4445 (TTY: 711) 번으로 전화해 주십시오

УВАГА! Якщо ви розмовляєте українською мовою, ви можете звернутися до безкоштовної служби мовної підтримки. Телефонуйте за номером 1-800-878-4445 (телетайп: 711).

注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-800-878-4445 (TTY: 711) まで、お電話にてご連絡ください。

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-800-878-4445 (رقم هاتف الصم والبكم: 711).

ATENȚIE: Dacă vorbiți limba română, vă stau la dispoziție servicii de asistență lingvistică, gratuit. Sunați la 1-800-878-4445 (TTY: 711).

ប្រយ័ត្ន: បើសិនជាអ្នកនិយាយភាសាខ្មែរ, សេវាជំនួយផ្នែកភាសា ដោយមិនគិតថ្លៃ គឺអាចមានសំរាប់បំរើអ្នក។ ចូរ ទូរស័ព្ទ 1-800-878-4445 (TTY: 711)។

XIYYEEFFANNAA: Afaan dubbattu Oroomiffa, tajaajila gargaarsa afaanii, kanfaltiidhaan ala, ni argama. Bilbilaa 1-800-878-4445 (TTY: 711).

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-800-878-4445 (TTY: 711).

دیوری بگ. شما یرا گان یرا بصورت یر زبان لات یر تسه، دی کن یم گفتگ و یر فارس زبان به اگر: توجه  
ف یم باشد. یا (TTY: 711) 1-800-878-4445 تماس

ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-800-878-4445 (ATS : 711).

เรียน: ถ้าคุณพูดภาษาไทยคุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร 1-800-878-4445 (TTY: 711)